We appreciate your interest in the USU Anatomical Gift Program. Before completing the application, review the statements below and initial each as applicable. If you do not agree with the terms and conditions, your request for anatomical gift donation will be declined. Once you've reviewed our terms, I ask you complete the Certificate of Donation. You can email, fax, or mail your application. Complete as much as you can, leaving blank date and place of death. Feel free to call with any questions (301-295-3334)

**(Place your initials next to the appropriate statement)**

I / the donor have not been diagnosed with COVID-19:\_\_\_\_\_\_\_\_\_

I / the have been vaccinated for COVID-19: \_\_\_\_\_\_\_\_

I / the will provide proof of COVID-19 vaccination: \_\_\_\_\_\_\_\_\_\_

I / the will provide a COVID-19 negative test: \_\_\_\_\_\_\_\_\_\_

I / the donor will provide photo ID for donation: \_\_\_\_\_\_\_\_\_

**(Certified death certificates)**

My next of kin will pay a flat fee of $100\* to file death certificates \_\_\_\_\_\_

I agree to pay the per copy charge per state death certificate\_\_\_\_\_\_

(Maryland $12-13)\* (Virginia $12)\* (West Virginia $12)\* (Washington, DC $18)\*

If the death occurs in West Virginia I will pay $50\* for the Cremation Permit\_\_\_\_\_

**(Laboratory Bloodwork Screening)**

If the donor blood panel are positive for any infectious disease, I will pay a contracted cremation fee up to $375\* to USU funeral contractor\_\_\_\_\_\_

**Select one or more donor program option(s):**

I agree to anatomical donation up to 4 months\_\_\_\_\_\_\_\_

I agree to anatomical donation up to 1 year\_\_\_\_\_\_\_\_

I support long term research, I agree to anatomical donation up to 2 years\_\_\_\_\_

**(End of Program)**

My family will accept the cremated remains from USU when anatomical usage ends\_\_\_\_\_\_

I have selected burial or inurnment at a local, National or VA Cemetery \_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_